ARC 3184C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services hereby amends Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 83, "Medicaid Waiver Services," Iowa Administrative Code.

Iowa's Medicaid program is evolving to create a single system of care to address the health care needs of the whole person, including the physical health, behavioral health, and long-term care services and supports. The purposes of these amendments are to deliver quality, patient-centered care and to create efficiencies. On April 1, 2016, the majority of Medicaid members began having their services coordinated through managed care organizations (MCOs). Members in the following programs are not included in this transition: the Health Insurance Premium Payment (HIPP) Program, programs for the medically needy, and programs for all-inclusive care for the elderly (PACE) enrollees, as well as members who are American Indian or Alaskan natives, or those who participate in the Medicare Savings Program.

These amendments are intended to implement changes related to managed care and provide technical clarification. Changes include:

- Replacing references to "service worker" with references to "designated case manager" as members of the AIDS/HIV, health and disability (H&D) and physical disability (PD) waivers will have community-based case managers through their MCOs or through fee-for-service Medicaid.
- Replacing outdated references to "Case Management Comprehensive Assessment" under the brain injury (BI), elderly, and children's mental health (CMH) waivers with references to a Department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148) to enable MCOs and the Iowa Medicaid Enterprise (IME) to utilize the interRAI assessment tool or another Department-approved standardized assessment tool for level of care determinations for the six home- and community-based services (HCBS) waiver programs and the needs-based eligibility determinations for the HCBS habilitation program.
- Replacing outdated references to "service worker assessment" under the AIDS/HIV, H&D and PD waivers with references to Form 470-4694 for children under the age of four and, for all others, a Department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148) to enable MCOs and IME to utilize the interRAI assessment tool or another Department-approved standardized assessment tool.
- Adding completion of Form 470-4694 for children under the age of five for the intellectual disability waiver.
- Adding three diagnoses for brain injury: cerebral edema, cerebral palsy, and status epilepticus.
- Adding definitions for "integrated health home" and "care coordinator" to the CMH waiver.

The Department implemented the IA Health Link Program on April 1, 2016. The majority of HCBS waiver members receive comprehensive care coordination through an MCO.

For state fiscal year 2017, funds were appropriated to be used to support the development and implementation of standardized assessment tools for persons with mental illness, an intellectual disability, a developmental disability, or a brain injury.

These amendments allow for use of Form 470-4694 for children under the age of four and, for all others, the interRAI assessment tool in the AIDS/HIV, BI, CMH, elderly, H&D and PD waiver programs and the HCBS habilitation program, bringing the Department's rules into compliance with the 2013 legislative mandate, the recommendations of the redesign stakeholder groups, current practice, and Iowa's Balancing Incentive Program application.

Authorized by Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), the Balancing Incentive Program provides enhanced Federal Medical Assistance

Percentages (FMAP) to states that spend less than 50 percent of long-term care dollars on care provided in home- and community-based settings. To qualify for these funds, states must implement three structural changes in their systems of community-based long-term services and supports (LTSS): a no wrong door/single entry point (NWD/SEP) eligibility determination and enrollment system; core standardized assessment instruments; and conflict-free case management. The Balancing Incentive Program requires the following of participating states: "development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs."

The IME and MCOs will use Form 470-4694 for children under the age of four and, for all others, the interRAI assessment tool for initial and annual assessments. The interRAI is a nationally recognized assessment tool that was developed for use with adults in home- and community-based settings. The instrument is generally used with the frail elderly or persons with a disability who are seeking or receiving formal health care and supportive services. The interRAI was first developed in 1994. Initially, it was designed to be compatible with the long-term care facilities system and was implemented in nursing homes.

The decision to use the interRAI was highly vetted by the Department. The development, selection, and use of a core standardized assessment (CSA) were part of the Balancing Incentive Program in Iowa. The CSA selection process started in May 2015, with statewide webinars and in-person listening and learning sessions designed to seek input from members, advocates, providers, and case managers. These listening and learning sessions were used to educate and inform individuals about various CSAs. After reviewing feedback and comments from the sessions, the Department selected the interRAI assessment tool for use with HCBS waiver and habilitation program members. The interRAI best matched the core domains of the Balancing Incentive Program criteria and included superior inter-rater reliability.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 2920C** on February 1, 2017.

The Department received comments from one respondent during the public comment period. The respondent's comments and the Department's responses are as follows:

Comment 1: "Based on a request for public comment by DHS in April 2016 and the results thereof, Iowa Legal Aid understands that DHS has designated the interRAI Home Care (HC) for waiver populations (except the Intellectual Disability Waiver, which will use a SIS assessment), and has recommended that the MCOs use the interRAI Community Mental Health (CMH) for the children's mental health waiver and Habilitation waivers. The proposed changes in **ARC 2920C** do not specify which tools will be used to evaluate level of care, however. Instead, the proposed changes identify the assessment tools as 'A department-approved comprehensive functional assessment tool that meets the requirements of Section 10202 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148).' The assessment tools currently being used by the Department, and any tools that may be used by the Department in the future, should be both identified by name and also made available to the public. We request that DHS add language to the regulations in question that does the following: 1) designates the name of the assessment tool being used for any particular waiver program; and 2) requires DHS to make a copy available to the public upon request and on the DHS website. In addition, Iowa Legal Aid requests a copy of both assessment tools (InterRAI CMH and HC) that will be or are being used by the State and MCOs."

Department response 1: The Department has revised the administrative rules to name the assessment tool to be utilized under each waiver program. The waivers and associated tools are as follows:

HCBS Core Standardized Assessment Tools

HCBS Waiver Level of Care Assessment Tools	AGE	AIDS/ HIV	BI	HD	PD	Elderly (EW)	CMH	ID
Case Manager Comprehensive Assessment (or modified PIHH for CMH)								
	0-3	X	X	X			X	
	0-4							X
interRAI - Pediatric Home Care (PEDS - HC)	4-20	X	X	X				
	18-19							
	18-20				X			
interRAI - Home Care (HC)	21+	X	X		X			
	21-64			X				
	65+					X		
interRAI - Child and Youth Mental Health (ChYMH)								
	4-20					X		
	16-18							
interRAI - Child and Youth Mental Health (ChYMH) and Adolescent Supplement	12-18						X	
Supports Intensity Scale Child (SIS-C)	5-15							X
Supports Intensity Scale Adult (SIS-A)	16+							X

HCBS Habilitation	HCBS Habilitation and HCBS Waiver (when a member is requesting to participate or is participating in the HCBS Habilitation program and a HCBS Waiver program).								
	AGE	HAB	AIDS/ HIV HAB	BI HAB	HD HAB	PD HAB	EW HAB	ID HAB	CMH HAB
interRAI - Child and Youth Mental Health (ChYMH)	16-18	X	X	X	X	X			
interRAI - Community Mental Health (CMH)	19-64	X	X	X	X	X			
	65+						X		
Supports Intensity Scale (SIS)									
Supports Intensity Scale Adult (SIS-A)	16+							X	

The rules were also revised to provide that copies of all assessment tools are available upon request from the Department of Human Services. The Department cannot post the interRAI tools or the Supports

Intensity Scale (SIS) tools on the Department's Web site, nor can it provide blank assessments because of copyright restrictions on those proprietary tools.

Specifically, the revisions to the rules are as follows:

1. Paragraph 78.27(2)"d" in Item 3 has been revised to read as follows:

"*d. Needs assessment.* The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

"(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

"(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter."

2. The introductory paragraph of 83.2(1)"d" in Item 4 has been revised to read as follows:

"*d.* The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - PEDS-HC and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization."

3. Subparagraph (1) of paragraph 83.2(2)"a" in Item 5 has been revised to read as follows:

"(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)*'d'* and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly."

4. The introductory paragraph of paragraph 83.22(1)"d" in Item 9 has been revised to read as follows:

"*d.* Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from the IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual's case manager or managed care organization."

5. Paragraph 83.23(3)"c" in Item 12 has been revised to read as follows:

"*c.* An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1)*'d,'* indicating that the applicant has elected waiver services."

6. The introductory paragraph and subparagraph (1) of paragraph 83.42(1)"b" in Item 13 have been revised to read as follows:

"*b.* Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

"(1) The assessment as listed in 83.42(1)*'b'* shall be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care."

7. Paragraph 83.42(2)"a" in Item 14 has been revised to read as follows:

"*a.* The designated case manager shall review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1)*'b'* and other supporting documentation as relevant."

8. An amendment to paragraph 83.82(1)"f" was added in new Item 23. The paragraph now reads as follows:

"*f.* Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission for an individual are available to that individual from the individual's case manager or managed care organization."

9. Paragraph 83.83(2)"c" in Item 24 has been revised to read as follows:

"*c.* An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph 83.82(1)*'f,'* indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager."

10. The introductory paragraph of subrule 83.87(3) in Item 26 has been revised to read as follows:

"**83.87(3)** *Annual assessment.* The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1)*'f'* and other supporting documentation as relevant."

11. The introductory paragraph of paragraph 83.102(1)"h" in Item 27 has been revised to read as follows:

"*h.* Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission for an individual are available to that individual from the individual's case manager or managed care organization."

12. Subparagraph 83.102(2)"a"(1) in Item 28 has been revised to read as follows:

"(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)*'h,'* as well as the availability and appropriateness of services."

13. The following paragraphs in subrule 83.103(2) in Item 29 have been revised.

Subparagraph (1) of paragraph "a" now reads as follows:

"(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1)*'h.'*"

Subparagraph (1) of paragraph "b" now reads as follows:

"(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1)*'h'* and submit it to the IME medical services unit."

Paragraph "d" now reads as follows:

"*d.* An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services."

14. The introductory paragraph of subrule 83.107(2) in Item 31 has been revised to read as follows:

"**83.107(2)** *Annual assessment.* The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*'h'* and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1)*'h'* and other supporting documentation as relevant."

15. Subrule 83.122(3) in Item 33 has been revised to read as follows:

"**83.122(3)** *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI Adolescent Supplement shall also be completed in addition to the interRAI – Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator or managed care organization."

16. An amendment to paragraph 83.125(1)"b" was added in new Item 37. The paragraph now reads as follows:

"*b.* The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant."

17. Subrule 83.127(3) in Item 39 has been revised to read as follows:

"**83.127(3)** The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant."

As requested, copies of all assessments or information submission tools have been provided to the respondent.

Comment 2: "We request that DHS implement and/or require standardized training on these assessment tools for any State personnel, MCO personnel, or third party contractor personnel who will be using the assessment forms to determine Level of Care and monthly level of supports or services for waiver applicants and recipients. The reason for this request is that concerns have been raised in other states about these assessment tools being used in an inconsistent manner. The training should be ongoing and include periodic inter-rater reliability testing. The preamble to this proposed rulemaking indicated that the 'interRAI best matched the core domains of the Balancing Incentive Program criteria and included superior inter-rater reliability.' The reason that the underlying data indicated that it includes superior inter-rater reliability, presumably, is that the raters go through training (not just initial training, but also follow-up training) and their scores are cross-referenced to ensure that the raters are correctly asking the questions to the waiver applicants and recipients and correctly scoring the answers provided to them. The requirement for continual training and inter-rater testing should be included in the rules."

Department response 2: The Department will not revise the rules based on the respondent's comment. The qualifications and training required to perform the assessments are contractually required.

The inter-rater reliability of the Supports Intensity Scale (SIS) is .87, which is in the "excellent" range based on conventional standards for adaptive behavior scales. A recent study by Thompson et al. showed that being properly trained in administering SIS plays a major role in obtaining reliable results from a SIS assessment. The American Association on Intellectual and Developmental Disabilities (AAIDD)

offers several types of SIS training to customers based on their specific stage of implementation. These training programs are SIS stakeholder session/respondent orientation, SIS train-the-interviewer training, SIS train-the-trainer training, and SIS quality assurance training. The order of these training programs also represents a general timeline from the initial steps of basic training to the more advanced, follow-up types of training.

The interRAI Training Community is a resource for trainers of the various interRAI instruments being used around the globe. The mission of the community is to help ensure consistent interpretation of the interRAI guidelines, as well as to provide trainers with resources to help them provide high-quality training. This online community site has been created by the interRAI Training Committee, a committee created by interRAI, whose members include the interRAI organization and Assessment & Intelligence Systems, Inc. (AIS). This site provides advice and helpful resources to those who have implemented or are planning an implementation of the integrated suite of interRAI instruments. The guidance on this site follows the interRAI standards. InterRAI also provides for a local consult to organizations that have purchased licenses.

Comment 3: "We request that DHS require that a complete picture of an individual's functioning be obtained when completing the assessment tool. For example, if a section of the assessment tool asks about Physical Functioning, note should be taken both of the activity of daily living (ADL) independence/assistance level and Instrumental Activities of Daily Living (IADL) difficulty level."

Department response 3: The Department will not revise the rules based on the respondent's comment.

The interRAI - Home Care (HC) assessment form is a minimum data set screening tool that enables a trained assessor to assess multiple key domains of function, health, social support and service use. Particular interRAI - Home Care (HC) items also identify persons who could benefit from further evaluation of specific problems or risks for functional decline. These are triggers that link the interRAI - Home Care (HC) to a clinical assessment protocol (CAP). The CAPs contain general guidelines for further assessment.

The HC system supports a variety of research-informed decision support tools that assist the assessor in planning and monitoring care. These include:

- Scales for ADLs, cognition, communication, pain, depression, and medical instability.
- Clinical assessment protocols that contain strategies to address problem conditions as triggered by one or more HC item responses.
- Screening systems to identify appropriate outreach and care pathways for prospective clients (the MI Choice and MAPLe systems).
- A quality monitoring system (home care quality indicators (HCQIs)).
- A case-mix system that creates distinct service-use intensity categories (RUG-III/HC).

The SIS is a unique, scientific assessment tool specifically designed to measure the level of practical supports required by persons with an intellectual disability to lead normal, independent, and quality lives in society. The SIS must be completed for each participant once in a three-year time period. During the two "off" years, an off-year assessment tool will be utilized for annual level of care redeterminations for adults. For children, the Case Management Comprehensive Functional Assessment Tool, Form 470-4694, is used each year.

The IME Medical Services Unit may request additional information from the service worker, case manager, health home coordinator, or community-based case manager to clarify or supplement the information submitted with the assessment. The results of the assessment are used to develop the plan of care. Because the same criteria are used for both institutional care and waiver services, the outcome is reliable, valid, and fully comparable.

Comment 4: "Interviews with waiver applicants and recipients should be face-to-face in the individual's place of residence. This will allow the interviewer to notice things that would not be apparent in a phone interview. These face-to-face interviews will also allow the interviewer to watch the individual perform functional tests and evaluate the home setting for any potential safety concerns or needed modifications. The rules should include language requiring a face to face meeting for the assessments."

Department response 4: The Department will not amend the rules based on the respondent's comment. While the Department agrees that the member's home may be the optimal location to accurately assess a member, the member must be afforded the choice of where the assessment will occur. The interRAI and the SIS assessment tools require a face-to-face interview at a time and place chosen by the member as required by 42 CFR 441. The off-year assessment completed for the ID waiver is completed telephonically unless the member has experienced a significant change, in which case a complete SIS assessment is scheduled.

Comment 5: "There should be a caregiver assessment, which is complementary to, but independent from the evaluation of an individual's assessed needs. The assessment tool should not coerce family members to stand in for professional caregivers to satisfy an individual's needs or assume the continued short-term help of a family member. The rules should include language reflecting the voluntary nature of assistance from family members, friends, and neighbors when asking about possible caregivers in the assessment."

Department response 5: The Department will not revise the rules based on the respondent's comment. The assessment tool is not intended to assess the needs of the member's caregiver or the immediate availability of natural supports. The intent and purpose of the assessment is to identify the applicant's or member's functional needs that would otherwise be met in a nursing facility or intermediate care facility for persons with an intellectual disability were it not for the member's choosing to receive waiver services in the home and community.

Comment 6: "It appears that DHS will be requiring the entity or individual responsible for developing the comprehensive service plan to use the results of the completed assessment to develop the comprehensive service plan. If the State or MCO will be applying some sort of algorithm or formula to the data collected during the assessment process to determine whether an applicant or recipient meets the Level of Care requirement for a waiver program and/or to determine a monthly level of support/services, the algorithm or formula (and any changes thereto) should be included in the rules. If a waiver applicant or recipient disagrees with the decision made by the State or MCO regarding eligibility for a waiver program or monthly level of support/services, the ability to challenge the decision is hampered when the applicant or recipient does not have access to the underlying decision-making process. If only certain sections of the assessments will be used, those sections should be identified in the rules."

Department response 6: The Department will not amend the rules based on the respondent's comment. This rule making does not address applying any algorithm or formula to the information collected during the assessment process in determining level of care and the level of support/services provided. The interRAI assessment tools are information-gathering tools. They do not provide any "result" that determines level of care or the level of support/services. And the use of new tools does not change the standards applied to the information collected to determine level of care or the level of support/services. To clarify that the assessment tools are information collection tools, the rules have been revised to uniformly refer to Level of Care and level of support/service decisions based on "information submitted on" completed assessment tools, as opposed, for example, to decisions "based on" the assessment tools. That change is reflected in revised amendments listed above in response to Comment 1.

The completed assessment tools are used in their entirety in addition to other supporting documentation as relevant when determining whether a member meets the level of care criteria in rule and in determining the level of support/services provided.

Comment 7: "Given the likelihood that members will be terminated from waiver services due to the use of a new assessment tool, we ask that DHS implement a grandfather clause in the rules which would protect eligibility for current waiver recipients going forward. There is also concern that the number of services and/or hours that waiver recipients receive could be cut due to the usage of these new assessment forms. This is especially concerning since a large number of individuals who receive waiver services are currently enrolled with AmeriHealth Caritas (AHC), one of lowa's MCO's, and AHC has announced that it will be moving individuals from their community case managers (who know them well and in many cases have worked with the individuals for years) to in-house AHC case managers. In order to protect

individuals from losing their waiver services (which enable to them to remain in the community), there should also be a grandfather clause in the rules protecting current levels of service for recipients."

Department response 7: The Department will not revise the rules based on the respondent's comment. The HCBS waiver member is required to have a level of care completed on an annual basis. The level of care criteria remain unchanged. During the level of care review prior to denial of level of care based on the results of the assessment, additional information is sought that would substantiate the member's functional status. As far as grandfathering in current waiver members, individual's needs change over time and the State makes assurance to CMS that a waiver member's needs will be reassessed annually at a minimum or when there is a significant change in the member's needs or condition.

Comment 8: "If a waiver applicant is denied eligibility, or a recipient is terminated from waiver eligibility or receives a reduction in services, the rules should require that a completed copy of the assessment tool for that applicant or recipient be attached to the notice of decision to ensure due process to applicants and recipients. See *Mocznianski v. Ohio Department of Job and Family Services*, 195 Ohio App. 3d 422 (Ohio Ct. App. 2011), *Baker v. Department of Health and Social Services*, 191 P3d 1005 (Alaska 2008), and *K.W. v. Armstrong*, F.R.D. 479 (D. Idaho March 24, 2014), order clarified by Nos. 1:12-cv-22, 3:12-cv-58 (D. Idaho Feb. 13, 2015), affirmed, 789 F.3d 962 (9th Cir. 2015). We also request that the rules require the notice of decision contain clear language about why the application is denied, or the coverage is being terminated or services reduced. The rules should also state that recipients must be informed of their right to continue benefits pending a final administrative decision. A reference to 441 IAC 7.9 would suffice in these proposed rules, however, the notice of decision must contain language informing the recipient of their right to request continuing benefits with in the applicable time period."

Department response 8: The Department will not revise the rules based on the respondent's comment. For all waiver programs, current appeal rights rules under 441—Chapter 7 already provide as follows:

"Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department."

See Iowa Admin. Code 441-83.9, 83.29, 83.49, 83.69, 83.89, 83.109, 83.129. The rules in 441—Chapter 7 require that the Department provide notice of any denial, termination, or reduction of assistance that includes "[a] clear statement of the specific reasons supporting the intended action" and "[t]he circumstances under which assistance is continued when an appeal is filed," as provided by Iowa Admin. Code 441 r. 441-7.9. See Iowa Admin. Code 441-7.6(1)(a), 7.7(1). Further, 441—Chapter 7 provides that within ten days of the receipt of an appeal, the Department worker or agent responsible for representing the Department at the hearing shall provide the appellant and the presiding officer with "a summary and supporting documentation of the worker's or agent's factual basis for the proposed action." Iowa Admin. Code 441-7.8(9). Prior to and during the hearing, 441—Chapter 7 also provides that the Department shall provide the appellant the opportunity to examine all materials to be offered as evidence. Iowa Admin. Code 441-7.13(1). In addition, 441—Chapter 7 also addresses numerous other matters relevant to notices of decision and appeals, such as hearing procedures and notice thereof.

The Department of Human Services has generally included completed copies of assessment tools with Department appeal summaries in administrative appeals involving Department action based on information contained therein, and the Department will continue to do so. The Department has also revised the rules to provide, consistent with existing policy, that copies of an individual's completed information submission tool is available from the individual's case manager or managed care organization at any time. Those revisions are also reflected in the revised amendments listed above in response to Comment 1.

In light of the Department's general appeal process, as shown in 441—Chapter 7, and the availability of completed assessment tools any time, the Department does not believe that due process requires the

attachment of the assessment tools to notices of decision, or the other rule changes requested. Rather, the Department believes that the existing references to 441—Chapter 7's notice and appeal requirements are adequate to ensure due process to applicants and recipients. Providing further specificity in rules regarding particular benefits or eligibility groups is unnecessary and potentially confusing.

The Council on Human Services adopted these amendments on June 14, 2017.

These amendments do not provide for waivers in specified situations because requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective August 9, 2017.

The following amendments are adopted.

ITEM 1. Amend subrule 77.25(5) as follows:

77.25(5) *Case management.* ~~The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is~~ A provider is eligible to participate in the home- and community-based habilitation services program as a provider of case management services ~~provided that the agency meets the standards in~~ if accredited as a case management provider pursuant to 441—Chapter 24.

ITEM 2. Amend subrule 77.29(1) as follows:

77.29(1) *Standards in 441—Chapter 24.* Providers shall ~~meet the standards in~~ be accredited as case management providers pursuant to 441—Chapter 24 ~~when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties~~ as a condition of providing case management services to persons with ~~mental retardation~~ an intellectual disability, developmental disabilities or chronic mental illness.

ITEM 3. Amend paragraph **78.27(2)"d"** as follows:

d. Needs assessment. ~~The member's case manager or integrated health home care coordinator has completed an assessment of the member's need for service, and based on that assessment, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services.~~ The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) ~~Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.~~ Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) ~~Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).~~ Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

ITEM 4. Amend paragraph **83.2(1)"d"** as follows:

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program~~ a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC)

for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) ~~A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.~~ The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in rule 441—90.5(249A).

(2) to (4) No change.

ITEM 5. Amend paragraph **83.2(2)"a"** as follows:

a. The member shall have a service plan approved by the department which is developed by the ~~service worker or targeted~~ designated case manager ~~identified by the county of residence~~. This service plan must be completed prior to services provision and annually thereafter.

The ~~service worker or targeted~~ designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed ~~Service Worker Comprehensive Assessment, Form 470-5044~~ information submission tool listed in paragraph 83.2(1)*"d"* and other supporting documentation as relevant. ~~Form 470-5044 shall be completed annually.~~ The ~~service worker or targeted~~ designated case manager shall have a face-to-face visit with the member at least ~~annually~~ quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The ~~service worker or targeted~~ designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) No change.

ITEM 6. Amend paragraph **83.3(3)"a"** as follows:

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) to (3) No change.

(4) The application is pending because a level of care determination has not been made although the ~~completed Form 470-4392, Level of Care Certification for HCBS Waiver Program,~~ required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment~~, Form 470-4392, or the service plan~~ has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, ~~Form 470-4392, or service plan,~~ the application shall be denied.

ITEM 7. Amend paragraph **83.3(3)"c"** as follows:

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign ~~Form 470-5044, Service Worker Comprehensive Assessment,~~ the assessment and indicate that the applicant has elected home- and community-based services.

ITEM 8. Amend paragraph **83.8(2)"d"** as follows:

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the ~~service worker or targeted~~ designated case manager.

ITEM 9. Amend paragraph **83.22(1)"d,"** introductory paragraph, as follows:

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program~~ the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI -

Home Care (HC) for an individual are available to that individual from the individual's case manager or managed care organization.

ITEM 10. Amend subparagraph **83.22(1)"d"(1)** as follows:

(1) ~~A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392~~ The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

ITEM 11. Amend paragraph **83.22(2)"a"** as follows:

a. Case management. Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to ~~441—subrule 77.33(21)~~ rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

ITEM 12. Amend paragraph **83.23(3)"c"** as follows:

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign ~~Form 470-4694, Case Management Comprehensive Assessment,~~ the information submission tool specified in 83.22(1)*"d,"* indicating that the applicant has elected waiver services.

ITEM 13. Amend paragraph **83.42(1)"b"** as follows:

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program~~ a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) ~~A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392~~ The assessment as listed in 83.42(1)*"b"* shall be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care.

(2) and (3) No change.

ITEM 14. Amend paragraph **83.42(2)"a"** as follows:

a. The ~~department service worker~~ designated case manager shall ~~perform an~~ review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This ~~assessment~~ review shall be based, in part, on information in the completed ~~Service Worker Comprehensive Assessment, Form 470-5044~~ information submission tool designated in 83.42(1)*"b"* and other supporting documentation as relevant. ~~Form 470-5044 shall be completed annually.~~

ITEM 15. Amend subparagraph **83.43(3)"a"(2)** as follows:

(2) The application is pending because a level of care determination has not been made although the completed ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program,~~ assessment has been submitted to the IME medical services unit.

ITEM 16. Amend paragraph **83.43(3)"c"** as follows:

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign ~~Form 470-5044, Service Worker Comprehensive Assessment,~~ the assessment and indicate that the applicant has elected home- and community-based services.

ITEM 17. Amend paragraph **83.61(2)"a"** as follows:

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, an SIS assessment.

ITEM 18. Amend subparagraph **83.61(2)"b"(1)** as follows:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, an SIS assessment for the initial level of care determination;

ITEM 19. Amend paragraph **83.61(2)"f"** as follows:

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange an SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the ~~worker~~ case manager can document difficulty in locating information necessary to arrange the ~~SIS~~ assessment or other circumstances beyond the ~~worker's~~ case manager's control.

ITEM 20. Amend subparagraph **83.61(2)"g"(1)** as follows:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor's off-year review.

ITEM 21. Amend rule 441—83.64(249A) as follows:

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) and **83.64(2)** No change.

ITEM 22. Amend rule **441—83.81(249A)**, definition of "Brain injury," as follows:

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.

Malignant neoplasms of brain, parietal lobe.

Malignant neoplasms of brain, occipital lobe.

Malignant neoplasms of brain, ventricles.

Malignant neoplasms of brain, cerebellum.

Malignant neoplasms of brain, brain stem.

Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.

Malignant neoplasms of brain, cranial nerves.

Secondary malignant neoplasm of brain.

Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.

Benign neoplasm of brain and other parts of the nervous system, brain.

Benign neoplasm of brain and other parts of the nervous system, cranial nerves.

Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.

Encephalitis, myelitis and encephalomyelitis.

Intracranial and intraspinal abscess.
Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

ITEM 23. Amend paragraph **83.82(1)"f"** as follows:

f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

ITEM 24. Amend paragraph **83.83(2)"c"** as follows:

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall ~~complete and~~ sign ~~Form 470-4694, Case Management Comprehensive Assessment,~~ the applicable information submission tool listed in paragraph 83.82(1)*"f,"* indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

ITEM 25. Amend paragraph **83.83(2)"d"** as follows:

d. The medical facility discharge planner, if there is one involved, shall contact the ~~appropriate case manager for the~~ consumer's ~~county of residence~~ managed care organization or the designated case manager to initiate development of the consumer's service plan and initiation of waiver services.

ITEM 26. Amend subrule 83.87(3) as follows:

83.87(3) *Annual assessment.* The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed ~~Form 470-4694, Case Management Comprehensive Assessment,~~ information submission tool listed in paragraph 83.82(1)*"f"* and other supporting documentation as ~~needed~~ relevant.

a. and *b.* No change.

ITEM 27. Amend paragraph **83.102(1)"h"** as follows:

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on ~~Form 470-4392, Level of Care Certification for HCBS Waiver Program~~ a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

~~(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person's condition, and annually for reassessment of the person's level of care.~~

~~(2)~~ (1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

~~(3)~~ (2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

ITEM 28. Amend subparagraph **83.102(2)"a"(1)** as follows:

(1) The ~~service worker~~ designated case manager shall identify the need for service based on the needs of the applicant, as documented in ~~Form 470-5044, Service Worker Comprehensive Assessment,~~ the information submission tool listed in 83.102(1)*"h,"* as well as the availability and appropriateness of services.

ITEM 29. Amend subrule 83.103(2) as follows:

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall ~~have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.~~ contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h."*

(2) No change.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's ~~primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program,~~ managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and submit it to the IME medical services unit.

(2) No change.

c. No change.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney

for health care shall sign ~~Form 470-5044, Service Worker Comprehensive Assessment~~ the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the ~~service worker or~~ designated case manager in the development of the service plan prior to the start of services.

f. and *g.* No change.

ITEM 30. Amend rule 441—83.107(249A), introductory paragraph, as follows:

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the ~~DHS service worker~~ designated case manager prior to services beginning and payment being made to the provider. ~~The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.~~

ITEM 31. Amend subrule 83.107(2) as follows:

83.107(2) *Annual assessment.* The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*"h"* and the appeal process at rule 441—83.109(249A), based on the ~~completed Form 470-4392, Level of Care Certification for HCBS Waiver Program,~~ appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and other supporting documentation as ~~needed~~ relevant.

a. and *b.* No change.

ITEM 32. Adopt the following **new** definitions of "Care coordinator" and "Integrated health home" in rule **441—83.121(249A)**:

"Care coordinator" means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)*"b."*

"Integrated health home" means the provision of services to enrolled members as described in 441—subrule 78.53(1).

ITEM 33. Amend subrule 83.122(3) as follows:

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator or managed care organization.

ITEM 34. Amend subrule 83.122(5) as follows:

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on ~~Form 470-4694, Case Management Comprehensive Assessment~~ the assessment.

ITEM 35. Amend paragraph **83.122(6)"a"** as follows:

a. The consumer must be a recipient of ~~targeted~~ case management or integrated health home services or be identified to receive ~~targeted~~ case management or integrated health home services immediately following program enrollment.

ITEM 36. Amend paragraph **83.123(1)"a"** as follows:

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or

~~(2) Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or~~

~~(3)~~ (2) A written request signed and dated by a Medicaid member's parent or legal guardian.

ITEM 37. Amend paragraph **83.125(1)"b"** as follows:

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed ~~department-approved assessment~~ information submission tool designated in 83.122(3) and other supporting documentation as ~~needed~~ relevant.

ITEM 38. Amend rule 441—83.127(249A), introductory paragraph, as follows:

441—83.127(249A) Service plan. The consumer's case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

ITEM 39. Amend subrule 83.127(3) as follows:

83.127(3) The service plan shall be based on information in ~~Form 470-4694, Case Management Comprehensive Assessment~~ the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

ITEM 40. Amend paragraph **83.128(2)"d"** as follows:

d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager or integrated health home care coordinator.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 7/5/17.